OREGON HEALTH AUTHORITY

Prepaid Health Plan Supplemental Payments

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Prepaid Health Plan (PHP) Supplemental Payments

Agenda

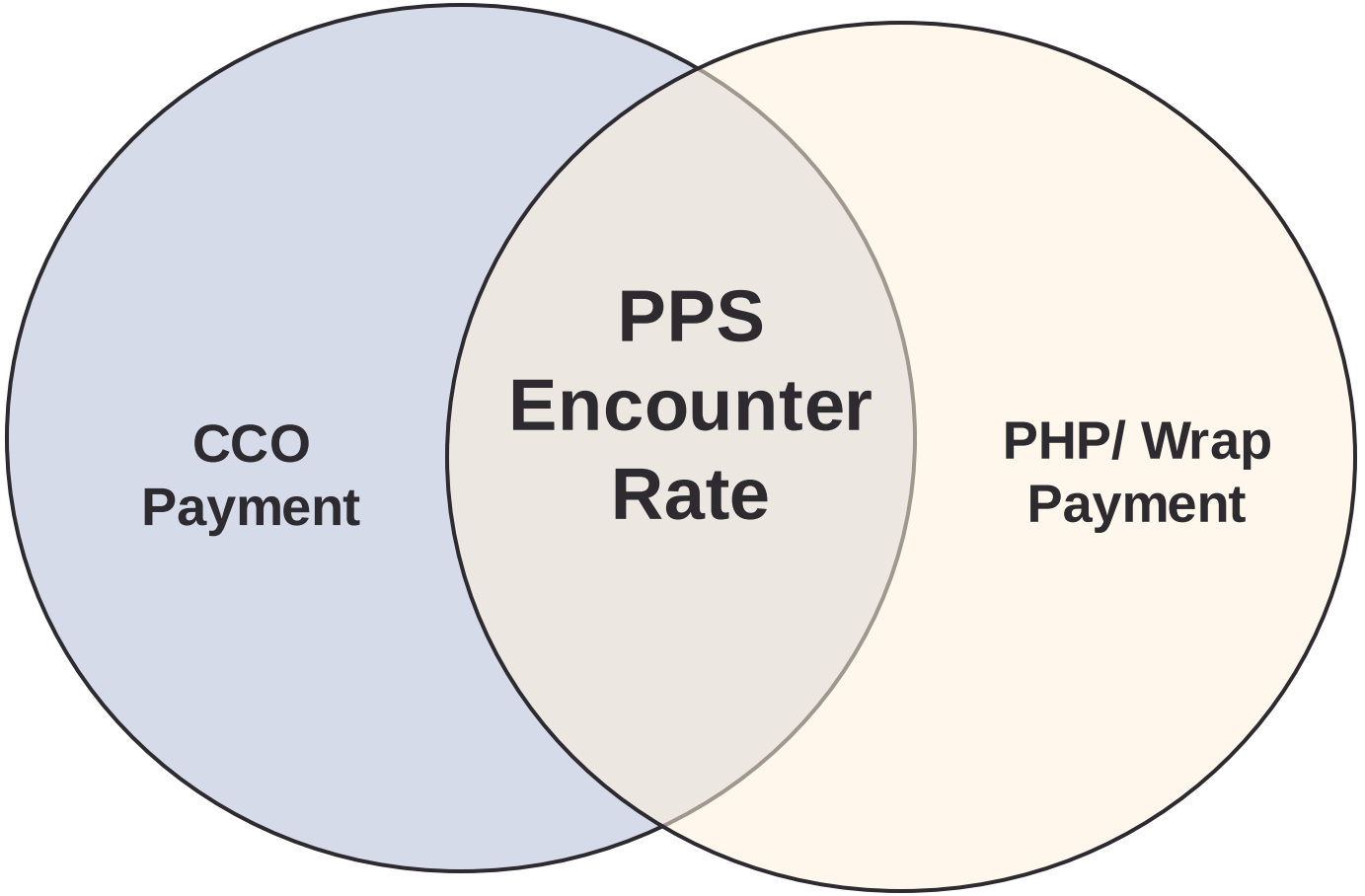
- Purpose of PHP Supplemental Payments
- Oregon Administrative Rules for Payments
- Process
- Responsibilities
- Exclusions
- Submission Template Review
- Technical Analysis
  - Payment Calculations
- Important Timeframes
- Wrap Around Payments Frequently Asked Questions (FAQs)
- Alternative Payment and Advanced Care Model (APCM) Participating Health Centers and Clinics
- Q & A

Purpose

- The Federal government guarantees reimbursement up to the PPS encounter rate for most services provided by an RHC or FQHC to Coordinated Care Organization members that if billed to OHA directly, would have paid at the PPS encounter rate .

- The PHP Supplemental Payment (also known as wrap-around payment) represents the difference, if any, between the payment received by the RHC/ FQHC from the CCO for treating the CCO enrollee and the payment to which the RHC/ FQHC would be entitled to.

Purpose



Applicable OARS

- 410-147-0460 Prepaid Health Plan Supplemental Payments
- 410-147-0360 Encounter Rate Determination
- 410-147-0120 Division Encounter and Recognized Practitioners
- 410-120-1280 Billing
- 410-120-1340 Payment

Process

1. Service is rendered and recognized as an “encounter” under OAR 410-147-0120
2. Clinic bills the contracted CCO
3. CCO submits encounter data to the Medicaid Management Information System (MMIS)
4. Clinic submits encounters and payments received to OHA for wrap-around payments

Responsibilities

Provider

- Bills for services rendered
- Receives payment from all payers
- Submits quarterly reports to OHA to receive payment, in aggregate, up to the encounter rate for qualified services

OHA Staff

- Reviews information submitted
- Compares to services submitted by the CCO
- Calculates wrap-around payment
- Provide a cover letter and summary of the payment calculation

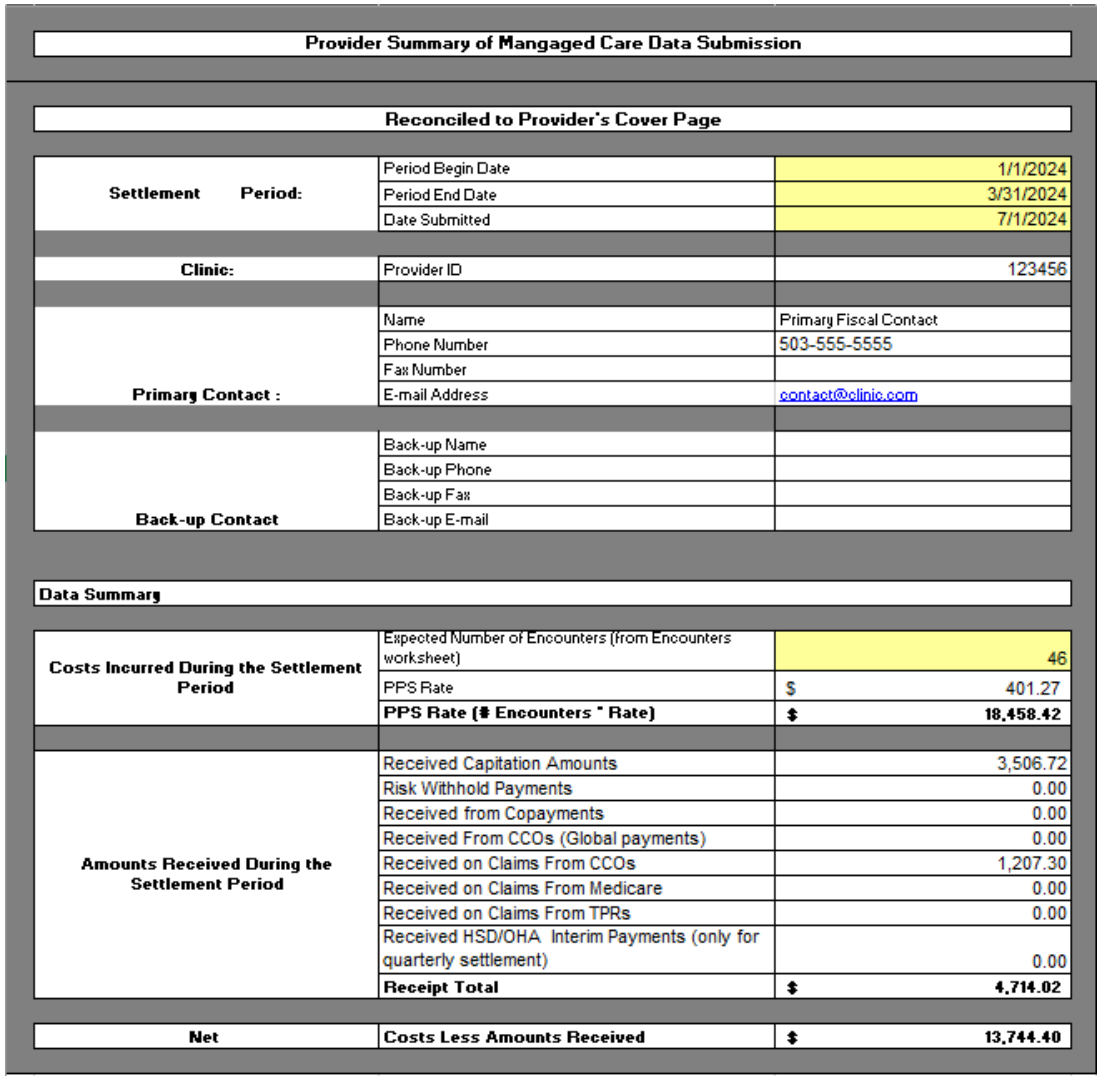
Exclusions

- PPS Eligible Benefit Packages – usually BMD, BMH, and BMM
- Excluded OHP Benefit Packages and PERC Codes
  - Benefit Packages – MED (Qualified Medicare Beneficiary – PERC code QB), CWM (Citizen Waived Medical)
  - Healthier Oregon Program (HOP) PERC codes
  - Note* Cover All Kids (CAK) and many CWM PERC codes have been rolled into HOP
    - CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, EM, EJ, EL, EK, H6,H7, H8, H9, HH, HI, HJ, HK, HN ,HO HP, HQ, HR, HS, HT, HU, HV, HX, HY, HZ

Exclusions

- OHP Bridge
  - Bridge Basic Health Program (BHP): all are CCO enrolled and **NOT PPS Eligible**
    - Benefit Package – BRG, PERC code – BE
  - Bridge Basic Medicaid: can be CCO enrolled or Fee for Service (FFS)/ Open Care and *are* **PPS/ Wrap Eligible**
    - Benefit Package – BRG, PERC code – PE
- Procedures excluded from Prospective Payment System encounter reimbursement; list located on the OHA FQHC/RHC web page

Submission Template



Provider Summary of Mangaged Care Data Submission

Reconciled to Provider's Cover Page

Settlement Period:	Period Begin Date	1/1/2024
	Period End Date	3/31/2024
	Date Submitted	7/1/2024
Clinic:	Provider ID	123456
Primary Contact :	Name	Primary Fiscal Contact
	Phone Number	503-555-5555
	Fax Number	
	E-mail Address	contact@clinic.com
Back-up Contact	Back-up Name	
	Back-up Phone	
	Back-up Fax	
	Back-up E-mail	

Data Summary

Costs Incurred During the Settlement Period	Expected Number of Encounters (from Encounters worksheet)		46
	PPS Rate	$	401.27
	PPS Rate (# Encounters * Rate)	**$**	**18,458.42**
Amounts Received During the Settlement Period	Received Capitation Amounts		3,506.72
	Risk Withhold Payments		0.00
	Received from Copayments		0.00
	Received From CCOs (Global payments)		0.00
	Received on Claims From CCOs		1,207.30
	Received on Claims From Medicare		0.00
	Received on Claims From TPRs		0.00
	Received HSD/OHA Interim Payments (only for quarterly settlement)		0.00
	Receipt Total	**$**	**4,714.02**
Net	**Costs Less Amounts Received**	**$**	**13,744.40**

Submission Template

C_Site	C_Client	C_NameLast	C_NameFirst	C_Prime	C_DOPSb	C_ProcCode	C_ProcCodeMod	C_DxCodeDet	C_AmtBilledDet	C_MCOPaidClmDet	C_MCOZeroExpl	C_McarePaidClmDet	C_McareZeroExpl
Clinic's Site ID	**Clinic's Client ID #**	**Client's Last Name**	**Client's First Name**	**Client's OMAP Prime ID**	**Date Of Procedure Service**	**Procedure Code**	**Procedure Code Modifier**	**Diagnosis Code**	**Detail amount billed.**	**Received on Claim from MCO (Outside of the per-member-per-month payment)**	**If zero, list explanation**	**Received On Claim From Medicare and/or TPR (if eligible)**	**If zero & Client is Medicare Eligible, List Explanation**
Use site abbreviation if this Provider ID has multiple sites.		Use the name as spelled on the client's OMAP ID card.	Use the name as spelled on the client's OMAP ID card.	Do not use the client's Social Security Number.	Choose whatever date format is easiest for you. All dates have to be in the same format. (MMDDYYYY, MM/DD/YY, etc.)	Use procedure code that was submitted to the MCO. Include rows for all procedures provided.	Use modifier submitted to MCO. Be sure to include the modifier 80, 81 or 82 for assist c-section.	ICD-9-CM diagnosis code must be at the highest specificity. Remove decimal point.	Detail amount billed.	If zero please indicate why in column "L". If client service reimbursed using per member per month, list zero and indicate pmpm in column "L".	For example use: PMPM = Service covered by cap pmt NC = Not covered by MCO OB = Global pmt Max = Medicare or TPR pmt in full OR type another explanation.	Clarification for zero payment only required for clients with Medicare benefit.	For example use: NC = Not covered Max = TPR pmt in full NA = Not applicable

Technical Analysis by Contracts & Fiscal Operations

- Review for data integrity
- Remove excludable CPT codes
- Sort for one encounter, per patient, per day
  - Medical
  - Dental
  - OBGYN
  - Mental Health/SUD
  - COVID vaccines (until DOS 5/11/23, end of PHE)
- Compare to CCO-submitted encounters in MMIS
- Remove encounters not matched exactly to MMIS
- Calculate final payment amount

Payment Calculation FAQ

- What if OHA calculates a different encounter count than we submitted?
  - 3% threshold over or under, defer to more conservative figure
  - Within the 3% threshold – processed as submitted
  - If OHA count is lower by more than 3%, OHA count is used as the basis for calculation
  - If clinic count is lower by more than 3%, clinic count is used as the basis for calculation

Encounter Count Test			**56**	
Clinic Submitted Count			**58**	
Difference			**(2)**	**-3.57%**

Payment Calculation FAQ

Managed Care Wraparound Payment Calculation
for the period January through March 2024

Provider #	Clinic Name	Submitted Encounters	Unmatched Encounters	Adjusted Encounters	PPS Rate	Total Reimbursable Cost
123456	*0*					
	Total Encounters MED	46	7	39	$ 401.27	$ 15,649.53
Total		**46**	**7**	**39**		**$ 15,649.53**

Unmatched Encounters	
Unmatched Encounters - Medical	5
Unmatched Encounters - Dental	-
Unmatched Encounters - Mental Health	-
FFS/ Open Card Encounters	2
Total	**7**

Reported CCO Payments	
Received Capitation Amounts	$ 3,506.72
Risk Withhold Payments	$ -
Received from Copayments	$ -
Received From CCOs (Global payments)	$ -
Received on Claims From CCOs	$ 1,207.30
Received on Claims From Medicare	$ -
Received on Claims From TPRs	$ -
Received HSD/OHA Interim Payments (only for quarterly settlement)	$ -
Total Payments	**$ 4,714.02**

CALCULATION OF MANAGED CARE WRAPAROUND PAYMENT	
Matched Reimbursable Encounters	$ 15,649.53
Reported Payments	$ 4,714.02
Total Wraparound Payment	**$ 10,935.51**

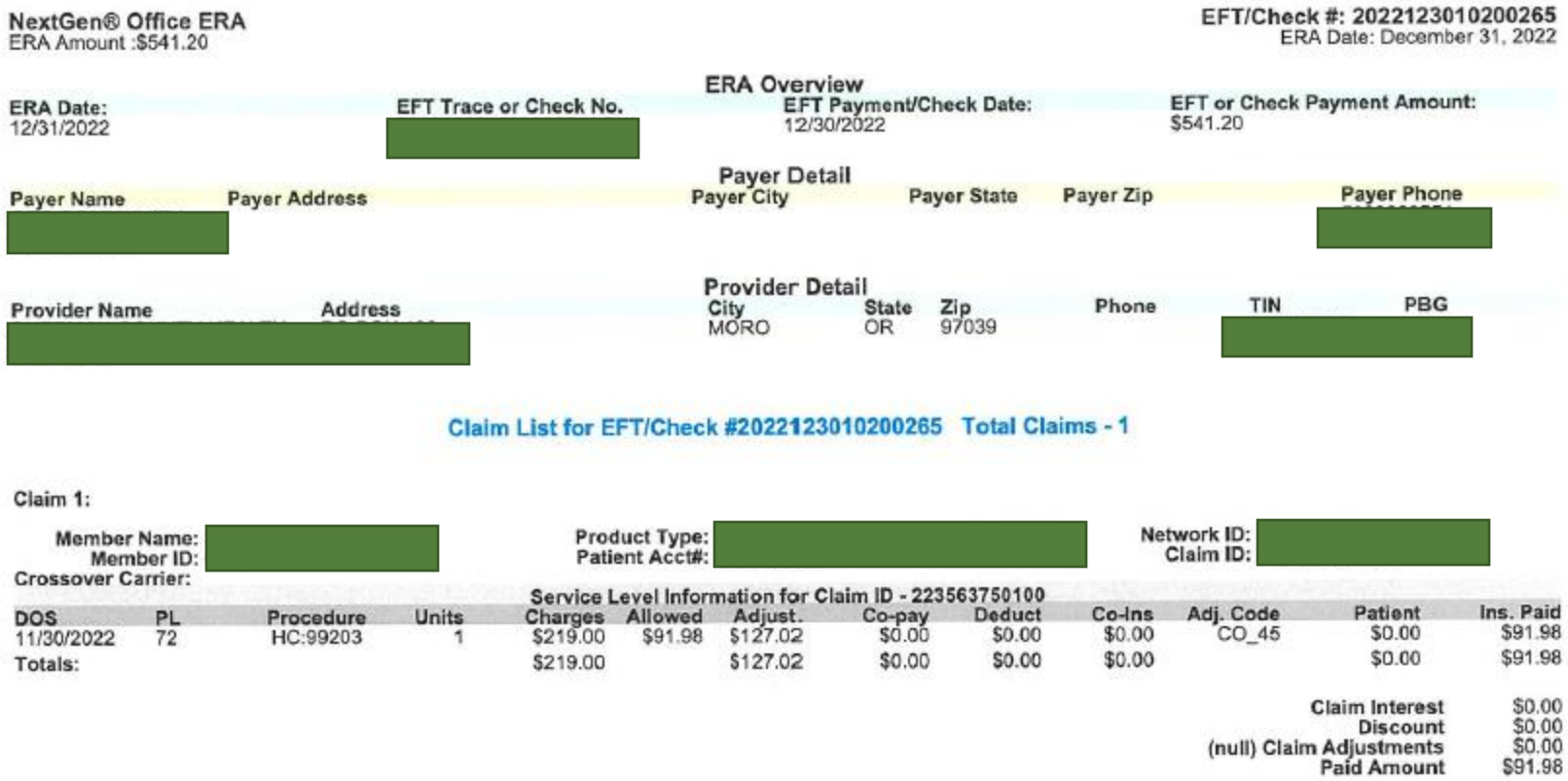
Technical Analysis by Contracts & Fiscal Operations

- Sent to Accounts Payable (+1 to 2 weeks)
- AP sends confirmation of payment activation through MMIS to Fiscal Analyst
- Clinic receives payment letter summarizing calculations and unmatched encounters

	Provider # **123456**
Primary Fiscal Contact	
You will be receiving a payment of $10,935.51; which represents the managed care full cost reimbursement for encounters occurring January through March 2024. From the encounter data you provided, I was able to reconcile all but 7 of the 46 encounters in our system.	
In reference to 42 USC 1396a(bb), HSD is required to reimburse managed care encounters at the PPS rate effective January 1,2024. This payment represents the cost per encounter rate of $401.27. This settlement check is considered final payment for these encounters for this reporting period.	

Technical Analysis by Contracts & Fiscal Operations

- 30 days to resubmit EOB's for any unmatched (not FFS)
- Secondary follow-up payment issued



NextGen® Office ERA
ERA Amount :$541.20

EFT/Check #: 2022123010200265
ERA Date: December 31, 2022

ERA Overview

ERA Date:	EFT Trace or Check No.	EFT Payment/Check Date:	EFT or Check Payment Amount:
12/31/2022	[redacted]	12/30/2022	$541.20

Payer Detail

Payer Name	Payer Address	Payer City	Payer State	Payer Zip	Payer Phone
[redacted]					[redacted]

Provider Detail

Provider Name	Address	City	State	Zip	Phone	TIN	PBG
[redacted]		MORO	OR	97039		[redacted]	

Claim List for EFT/Check #2022123010200265 Total Claims - 1

Claim 1:

Member Name: [redacted]
Member ID:
Crossover Carrier:

Product Type: [redacted]
Patient Acct#:

Network ID: [redacted]
Claim ID:

Service Level Information for Claim ID - 223563750100

DOS	PL	Procedure	Units	Charges	Allowed	Adjust.	Co-pay	Deduct	Co-Ins	Adj. Code	Patient	Ins. Paid
11/30/2022	72	HC:99203	1	$219.00	$91.98	$127.02	$0.00	$0.00	$0.00	CO_45	$0.00	$91.98
Totals:				$219.00		$127.02	$0.00	$0.00	$0.00		$0.00	$91.98

Claim Interest	$0.00
Discount	$0.00
(null) Claim Adjustments	$0.00
Paid Amount	$91.98

Important Timeframes for Wraparound Payments

Claims submitted to managed care/coordinated care organizations	Within four months from DOS
MCO/CCOs submit the data and amounts paid on claims into MMIS	Within 180 days from DOS
Overall OHA processing time	4-6 weeks from date of submission to agency (OHA)
EOB resubmissions for unmatched encounters	30 days from receipt of unmatched encounter list
Secondary follow-up payments	Up to 6 months from date of resubmission to agency

Wraparound Payment FAQ

- Which encounters should be reported on data submission?
  - INCLUDED
    - All services rendered to eligible OHP members
    - Multiple encounters per patient, per day
    - Global procedure codes
  - EXCLUDED
    - Services for members on any excluded benefit package and/ or PERC code
    - Services provided under a separate provider ID
    - Any service rendered outside of a CCO contract agreement

Wraparound Payment FAQ

- Which payments should be reported on the coversheet?
  - INCLUDE
    - All payments received from outside sources
    - Payment for all services including labs and radiology
    - When a service requires a copay, the copay must be reported as a payment, whether it was collected or not
    - CCO Capitation payments, Third Party Liability, Medicare, Risk Withhold
    - Payments received on global encounters
  - EXCLUDE
    - Bonus or incentive payments
- How frequently should wraps be submitted?
  - Monthly or quarterly
  - Federal law requires that Medicaid agencies reconcile at least every four months (OAR 410-147-0460)

Alternative Payment and Advanced Care Model (APCM) Participating Health Centers and Clinics

- Under the APCM program, the PPS encounter rates is translated to a Per-Member, Per-Month payments for eligible OHP members receiving Primary Care
- Medical Services for these members would not be submitted for wrap unless services fall under the carved-out services.
  - Typically - Obstetrics/ Prenatal Care, Addiction/Behavioral Health, and Dental Services
- If the PPS equivalent is less than PMPM payments received, the APCM participating health center or clinic would be reimbursed the difference through the Annual Reconciliation Process.
  - "*This reconciliation is intended to assure that the APCM revenue is at least as much as the PPS payments would have provided for the same time period. OHA will complete an annual payment reconciliation for the calendar year of Health Center's program participation where quarterly reports show APCM payments at a lesser amount than what PPS would have provided*." – APCM Participation Agreement

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Questions?

Thank you

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Adrienne Cooke at Adrienne.cooke@oha.Oregon.gov or 503-551-0630(voice/text). OHA 800-527-5772 for all relay calls.

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